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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675967 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER Northgate Plaza | | STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Northgate Dr Irving, TX 75062 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #1 and Resident #2) of ten residents reviewed for Reasonable Accommodation of Needs.</p> <p>The facility failed to ensure the call light was in reach and accessible for Resident #1 and Resident #2.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of Resident #1's Face Sheet, dated 10/30/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #1's pertinent diagnoses included unsteadiness on feet and muscle weakness.</p> <p>Review of Resident #1's Quarterly MDS Assessment, dated 09/30/2024, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident was dependent on staff for toileting, transfer, shower, dressing, and personal hygiene.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 10/28/2024, reflected the resident was at risk for falls due to unsteady gait and one of the interventions was to be sure the call light is within reach.</p> <p>Observation and interview with Resident #1 on 10/30/2024 at 9:15 AM revealed Resident #1 was in her bed, awake. It was observed that the resident's call light was on the floor. The resident stated she could not find her call light. The resident kept on searching for her call light at the side of the bed and on top of her head. She said she could not even find the cord of the call light.</p> <p>Resident #2</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #2's Face Sheet, dated 10/30/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #2's pertinent diagnoses included unsteadiness on feet and muscle weakness.</p> <p>Review of Resident #2's Quarterly MDS Assessment, dated 10/04/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident required moderate assistance for shower, dressing, and toileting hygiene.</p> <p>Review of Resident #2's Comprehensive Care Plan, dated 09/16/2024, reflected the resident was at risk for falls due to balance problems and one of the interventions to have a working and reachable call light.</p> <p>Observation and interview with Resident #2 on 10/30/2024 at 9:23 AM revealed Resident #2 was in her bed, awake. It was observed the resident's call light was on the floor. When the resident was asked where her call light was, the resident looked at the side of her bed and then shrugged her shoulders.</p> <p>Observation and interview with CNA C on 10/30/2024 at 9:29 AM, CNA C stated the call lights should be accessible to the residents to let the staff know that they needed something. CNA C said if the call lights were not within reach, the residents would not be able to call the staff and their needs would not be met. She said she did not notice the call lights were not with Resident #1 and Resident #2 when she did her morning round. CNA C went inside Resident #1's room, picked up the call light, and clipped it beside the resident. She then went inside Resident #2's room, picked up the call light, and handed it over to the resident. She said she would do her round to check if the residents on her hall had their call lights.</p> <p>In an interview with LVN B on 10/30/2024 at 12:30 PM, LVN B stated call lights should be with the residents all the time, because they use the call lights to call for help or assistance if needed. LVN B said the residents used the call lights to communicate to the staff that they needed something. She said without the call lights, the residents might fall trying to do things by themselves or get frustrated because they could not call the staff. She said all the staff were responsible in making sure the call lights were within reach of the residents. LVN B said the call light were for all residents, whether dependent or independent. LVN B said she would check the rooms of the residents to make sure call lights were with the residents.</p> <p>In an interview with the Interim DON on 10/31/2024 at 6:42 AM, the Interim DON stated call lights should be placed where the residents could access them without difficulty. The Interim DON said the call lights were the residents' mode of communication so they could tell the staff they needed something. He said the residents' need would not be addressed if the residents were not able to call the staff. The Interim DON said the call lights were for all the residents and all the staff were responsible in ensuring that the call lights were within reach. The Interim DON said the expectation was for the staff would be mindful that every time they leave the residents' room, the call lights were within reach of the residents. The Interim DON said he already started an in-service about the call lights when he was informed about the issue. He said he would personally monitor that all the residents' call lights were within reach.</p> <p>(continued on next page)</p> | | |

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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview with the Administrator on 10/31/2024 at 7:36 AM, the Administrator stated the call lights should be within the reach of the residents in case they needed the staff. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should make sure the call lights were within reach. The Administrator said he would coordinate with the DON regarding call lights and would constantly remind them that before leaving the room, make sure the call lights were with the resident. The Administrator concluded that they would re-educate the staff about call lights and monitor them closely.</p> <p>Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical</p> <p>revealed Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures . 5 . Place the call device within resident's reach before leaving room.</p> | | |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observation, interview, and record review, the facility failed to secure confidential and personal medical records for four (Resident #6, Resident #7, Resident #8, and Resident #9) of four resident reviewed for Privacy and Confidentiality.</p> <ol style="list-style-type: none"> The facility failed to ensure LVN B would not leave Resident #6's information about her death unattended and visible on top of the nurse's cart on 200 Hall. The facility failed to ensure LVN B would not leave Resident #7's schedule for Norco unattended and visible on top of the nurse's cart on 200 Hall. The facility failed to ensure LVN B would not leave Resident #8's schedule for Baclofen unattended and visible on top of the nurse's cart on 200 Hall. The facility failed to ensure LVN B would not leave Resident #9's vital signs and code status unattended and visible on top of the nurse's cart on 200 Hall. <p>These failures could place the residents at risk of exposure of their personal and medical information to unauthorized individuals.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Resident #6's Face Sheet, dated 10/30/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #6 was diagnosed with senile degeneration of the brain (age-related cognitive decline). <p>Review of Resident #6's Progress Notes, dated 10/30/2024, reflected Resident passed away early this morning and was declared dead by the RN on duty. Emergency contact . was informed.</p> <ol style="list-style-type: none"> Review of Resident #7's Face Sheet, dated 10/31/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #7 was diagnosed with pain to right knee. <p>Review of Resident #7's Quarterly MDS Assessment, dated 09/18/2024, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident was taking an opioid.</p> <p>Review of Resident #7's Physician Order, dated 06/18/2024, reflected Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug* Give 2 tablet by mouth every 6 hours for chronic generalized pain.</p> <ol style="list-style-type: none"> Review of Resident #8's Face Sheet, dated 10/31/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #8 was diagnosed with paraplegia (paralysis of the legs and lower part of the body). <p>(continued on next page)</p> | | |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #8's Quarterly MDS Assessment, dated 10/29/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident was paraplegic.</p> <p>Review of Resident #8's Physician Order, dated 08/23/2024, reflected Baclofen Tablet 20 MG. Give 1 tablet by mouth every 6 hours for muscle spasms.</p> <p>4. Review of Resident #9's Face Sheet, dated 10/31/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #8 was diagnosed with cerebrovascular disease (blood supply to the brain was interrupted).</p> <p>Review of Resident #9's Progress Note, dated 10/30/2024, reflected PATIENT ARRIVED AT THE FACILITY AT 11:45 AM AND WAS TRANSFERRED TO BED SAFELY WITH NO OTHER CONCERNS . INITIAL SET OF VITAL SIGN PARAMETERS WERE AS FOLLOWS; BP 164/85, PULSE 64, TEMP 97.5, O2 98% ON ROOM AIR AND RESPIRATION WAS 15.</p> <p>Review of Resident #9's Progress Note, dated 10/30/2024, reflected Date of Service: 10/30/2024 02:45 PM . Code Status: DNR - DO NOT RESUSCITATE.</p> <p>Observation on 10/30/2024 at 12:18 PM revealed a nurse's cart was parked in hall 200. On top of the cart where pieces of papers revealed the following:</p> <ul style="list-style-type: none"> * Resident #6's name, the time of her death, who pronounced her death, the resident's funeral home, who called the funeral home, who authorized the call, the name of the resident's children and their phone numbers, and who would sign the resident's death certificate. * Resident #7's name, the time Norco was administered, and the time the resident would take it again. * Resident #8's name, the time she took baclofen, and the time she would take it again. * Resident #9's name, room number, blood pressure, heart rate, respiratory rate, oxygen saturation, and his code status. <p>Observation and interview on 10/30/2024 at 12:22 PM revealed MA D walked towards the cart on hall 200, gathered the pieces of paper on top of the cart, flipped them over, and put it under a small pink bag. MA D stated she flipped the papers over because information about certain residents were exposed and could easily be read by persons passing by the hall. She said personal and medical information of a resident were confidential and should be kept unseen by others.</p> <p>(continued on next page)</p> | | |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview with LVN B on 10/30/2024 at 12:30 PM, LVN B stated she went to hall 100 to attend to another resident. She said she left her cart on hall 200. She said she usually wrote some information on a piece of paper so she would not miss anything for her documentation. She said she forgot to flip the papers over before she left the cart and went to hall 100. She said it was an oversight on her part and would make sure that every time she would leave the cart, no information about any resident were on top of the cart. She said written on the papers were information about the resident that passed away early morning, some information about the resident that was newly admitted , and some medications for several residents. She said she should have flipped over the papers or put them inside the carts. She said any information were confidential and she was supposed to provide privacy for all residents.</p> <p>In an interview with the Interim DON on 10/31/2024 at 6:42 AM, the Interim DON stated personal and medical information about a resident should not be exposed for everybody to see. He said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. He said all employees were expected to provide full privacy and confidentiality of information for all residents. The Interim DON stated the failure to not protect the resident information could cause poor self-esteem and embarrassment for the resident. The Interim DON stated he would start an in-service about privacy and confidentiality of the residents' information.</p> <p>In an interview with the Administrator on 10/31/2024 at 7:36 AM, the Administrator stated the staff must make sure the residents' information were not exposed because it was a violation of the residents' privacy and confidentiality of the care they were receiving. He said the expectation was for all the staff to make sure the residents' information and treatment were not visible to unauthorized individuals. He said he would collaborate with the DON to do an in-service about privacy and confidentiality.</p> <p>Record review of facility's policy, HIPPA Policy/ Procedure - Nursing Services revised 09/2022 revealed Policy: It is the policy of the company to ensure appropriate employee use of information systems resources, especially in relation to following all HIPA regulations . This policy applies to all users of our electronic network, systems, and workstations, including employees and other work force members.</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 5 (room [ROOM NUMBER], #2, #3, #4, and #5) of 5 resident rooms and the handrails reviewed for cleanliness and sanitization.</p> <p>*The facility failed to ensure that Resident Rooms #1, #2, #3, #4, and #5 were thoroughly cleaned and sanitized.</p> <p>*The facility failed to clean and sanitize the handrails, utilized by residents throughout the facility.</p> <p>These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.</p> <p>Findings included:</p> <p>An observation on 10/30/24 at 10:53 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The bathroom floor had thick black dirt along the corners of the floor and around the toilet. The bathroom wall had a large brown stain on it.</p> <p>An observation on 10/30/24 at 10:56 of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The bathroom floor had thick black dirt along the corners of the floor. On the floor around the toilet, there was brownish stains circling the toilet.</p> <p>An observation on 10/30/24 at 10:58 of the handrails throughout the facility, had dark and light stains on nearly all handrails.</p> <p>An observation on 10/30/24 at 11:00 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The air filters had thin layers of dust. The bathroom floor had thick black dirt along the corners of the floor. Behind the toilet was a large circular brownish stain. On the floor around the toilet, there was brownish stains circling the toilet.</p> <p>An observation on 10/30/24 at 11:02 AM of Resident room [ROOM NUMBER] reflected the bathroom floor had thick black dirt along the corners of the floor. Behind the toilet was a large brownish stain. On the floor around the toilet, there was brownish stains circling the toilet.</p> <p>An observation on 10/30/24 at 11:05 AM of Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black dirt debris and thick dusts. The air filters had thin layers of dust. There were reddish stains along the borders of the room floor.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview on 10/31/24 at 12:20 PM, the Housekeeping Supervisor, stated she had been at the facility almost two years. She stated housekeeping was supposed to clean the entire room, including the floor, bathrooms, and the air condition. She stated the air condition units were to be cleaned daily. She was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, and #5 and the handrails. She stated they recently hired a second housekeeping staff, so they were trying to get caught up. She stated they had to let the last housekeeping employee go because she was not cleaning the rooms thoroughly. She stated she was trying to make sure the rooms were being properly cleaned, which was why they implemented angel rounds, which involved department heads being assigned to resident rooms, and one of the areas that was observed was the cleanliness of the room. She stated the handrails in the halls were to be cleaned daily. She stated she had not received any concerns about the cleanliness of the room. She stated the risk of the resident rooms not being thoroughly cleaned could result in infections.</p> <p>In an interview on 10/31/24 at 1233 PM, Housekeeping G stated she had been with the facility since July 2024 but had over [AGE] years of experience as a housekeeping. She stated she cleaned everything in the room daily, including the bathrooms, air condition units, handrails, and floors. She was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, and #5 and the handrails, and she stated that it was mainly just her cleaning the rooms, so she did not have time to clean them thoroughly. She stated the risk of the residents' room not being thoroughly was that they could get sick.</p> <p>In an interview on 10/23/24 at 1:20 PM, the Administrator was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, and #5 and handrails. He stated housekeeping was short staffed on their staffing, but they had since hired staff and now trying to get caught up on doing more through cleanings. He stated the concerns observed is an infection control concerns and dignity.</p> <p>Review of the facility's policy on Safe / Comfortable / Homelike Environment (01/2022) reflected Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on interviews and record reviews the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Residents #4) of 4 residents reviewed for (ADLs) care provided to dependent residents.</p> <p>1. The facility failed to ensure Resident #4 received scheduled bed baths from October 1, 2024 - October 30, 2024.</p> <p>This failure placed the resident at risk of not receiving necessary services to maintain good personal hygiene, skin breakdown, and decreased self- esteem.</p> <p>Findings included:</p> <p>Record review of Resident #4's Face Sheet, dated 10/31/2024, revealed she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet.</p> <p>Record review of Resident #4's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive response) and for ADL care it stated, for transfers, toileting, and bathing, the resident required total assistance.</p> <p>Record review of Resident #4's Comprehensive care plane dated 06/11/24 revealed the resident was care planned for potential for pressure ulcers, and an intervention included head to toe assessments for skin breakdown during baths.</p> <p>In an interview on 10/30/24 at 11:00 AM, Resident #4 stated she was scheduled to receive three showers a week, but she was lucky to get just one a week. She stated she wanted her three showers a week because she did not want to be stink like some of the other residents in the facility.</p> <p>Record review of the facility's shower sheet for Resident #4 from 10/01/24 to 10/29/24 reflected the following shower sheets:</p> <p>*10/02/24: Refused</p> <p>*10/09/24: CNA commented on shower sheet: Resident #4 loved her shower.</p> <p>*10/11/24: CNA commented on shower sheet: Resident #4 enjoys all showers.</p> <p>*10/12/24: No comments provided.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 10/30/24 at 1:20 PM, the Acting DON stated he reviewed the shower sheets for Resident #4 and had only found 4 shower sheets for the resident. He stated the CNAs were supposed to complete shower sheets every time they were scheduled to provide the resident a shower. He stated if the resident had refused a shower, they were to still complete the shower sheet and indicate that the resident had refused a shower, and then notify the nurse for the resident to attempt to persuade the resident to take a shower. He stated he was unsure if the resident had received her showers or not for the month of October. He stated he had already in serviced his nursing staff today on Showers. He stated the resident was scheduled to receive her showers on Monday, Wednesday, and Friday. He stated the resident not receiving her showers could result in skin breakdown. He stated he was unaware of the resident having a history of refusing her showers.</p> <p>In an interview on 10/23/24 at 1:20 PM, LVN M stated she was the floor nurse for Resident #4. She stated she knew the CNA was responsible for providing the resident her shower and she knows for sure the CNA was providing showers to the resident. She stated the CNA who normally provided her showers was off today. LVN M, stated she did not know why the resident had made the allegation. She stated staff was supposed to complete a shower sheet for all resident, whether a shower was provided or not. She stated the risk of the resident not receiving her scheduled showers could result in skin breakdown, they could smell, and is a dignity issue.</p> <p>The facility's policy ADL, Services to carry out (11/2007), reflected It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675967 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER Northgate Plaza | | STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Northgate Dr Irving, TX 75062 | |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444</p> <p>Based on observations, interviews, and record review, the facility failed to implement interventions that are consistent with current professional standards of practice for 1 (Resident #11) of 9 residents reviewed for environmental hazards.</p> <p>Resident #11's mattress was raised up on one side using wedges and a pillow.</p> <p>Improper placement of the resident's mattress could put residents at risk for injury or entrapment.</p> <p>The findings included:</p> <p>Review of Resident #11's Face Sheet, dated 10/31/2024, reflected that Resident #11 was a [AGE] year-old female admitted on [DATE]. Resident #11 was diagnosed with acute and chronic respiratory failure with hypoxia (low levels of oxygen), severe intellectual disabilities, autistic disorder (condition that impairs the ability to communicate or interact with others), spastic hemiplegic cerebral palsy (muscle stiffness and lack of muscle control on one side of the body), cognitive communication deficit, and seizures.</p> <p>Review of Resident #11's Quarterly MDS (Minimum Data Set: tool used to assess health status of resident) Assessment, dated 08/26/2024, reflected a BIMS (brief interview for mental status) was not appropriate because resident is rarely/never understood. It also reflected Resident #11 had not experienced a fall since the prior assessment. Section GG reflected Resident #11 was dependent on staff to provide personal care.</p> <p>Review of Resident #11's Comprehensive Care Plan, dated 08/24/2024, reflected Resident #11 has a behavior problem as evidenced by rolling out of low bed onto mattress beside bed. One intervention was to Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.</p> <p>An observation on 10/30/24 at 09:20 AM revealed Resident #11 was lying in bed asleep. The bed was placed against the wall and a fall mat was next to the resident's bed. Resident #11's mattress was propped up 8 inches on one side, using wedges and a pillow, along the side of the bed that was opposite of the wall. Resident #11 was lying on the edge of the mattress, with a pillow between her head and the wall.</p> <p>In an interview on 10/30/24 at 09:25 AM, LVN B stated the mattress should not be raised up like this and she did not know who was responsible for it. She stated she peeked in the resident's room earlier that morning to make sure the resident had not rolled out of the bed onto the fall mat. She stated the room was dark and she did not notice the mattress was up on one side. She believed this was done on the night shift to prevent the resident was rolling out of the bed. LVN B removed the pillow and wedges.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/30/24 at 09:40 AM, CNA C stated the mattress was like that at the beginning of the shift. CNA C stated there was a fall mat next to the bed, in case the resident rolled out of bed, and the mattress should not have been propped up. She stated staff had to check on Resident #11 frequently to make sure the resident was ok and not trying to get out of bed.</p> <p>During an interview on 10/30/24 at 10:30 AM, the DON stated Resident #11's mattress should not have been placed like that. He stated propping up the mattress was not good practice and may be considered a restraint because it could prevent the resident from getting up. He stated the resident had a behavior of rolling out of the bed and there was a mattress on the floor to cushion and prevent injury. He stated the mattress on the floor was included in the resident's care plan. The DON stated the facility employed agency CNAs, and when there was a concern like this, he had in-service training to let staff know it was not part of the plan of care. He provided the phone number of the CNA who was on the schedule Tuesday night.</p> <p>In a telephone interview on 10/30/24 at 10:50 AM, CMA F stated she worked Sunday night, and her next scheduled shift was Wednesday night. She stated the DON called to see if she worked Tuesday night, and she told him no. CMA F stated the DON told her the resident's bed should not be raised up like that. She stated the resident had rolled out of bed before and there was a fall mat next to the bed. She stated they had to check on the resident often to make sure she didn't roll out of the bed.</p> <p>In an interview on 10/30/24 at 11:00 AM, RN E stated she and the DON had been contacting staff members but did not know who was responsible for propping up Resident #11's mattress. She stated Resident #11 had rolled out of the bed before, and staff made sure the fall mat was next to the resident's bed. RN E stated the intervention was care planned. It cushioned the fall and had prevented the resident from an injury. She stated it was not safe practice to use a resident's beds in a manner it was not made to be used and this could limit the resident's ability to move in the bed. She stated staff members would receive in-service training.</p> <p>Review of the facility's policy Least Restrictive Environment Policy reflects that the facility will provide their residents with the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being and risks of using restrictive behavior include entanglement, agitation, skin breakdown, contractures, incontinence, infection, decreased self-esteem, decline in muscle tone and function. Undated.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four (Resident #3, Resident #4, Resident #5, and Resident #10) of eight residents reviewed for Respiratory Care.</p> <ol style="list-style-type: none"> The facility failed to ensure that Resident #3's humidifier had water in it. The facility failed to ensure that Resident #4's breathing mask and nasal cannula (flexible tube used to deliver oxygen to the nose through two prong) were properly stored when not in use. The facility failed to ensure that Resident #5's nasal cannula connected to the portable tank behind the wheelchair was properly stored when not in use. The facility failed to ensure that Resident #10's nebulizer (machine that turns liquid medication into a mist and breathed directly into the lungs) face mask was properly stored. <p>These failures could place the residents at risk for respiratory infection and not having her respiratory needs met.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Resident #3's Face Sheet, dated 10/30/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #3 was diagnosed with chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). <p>Review of Resident #3's Quarterly MDS Assessment, dated 09/22/2024, reflected the resident was cognitively intact with a BIMS score of 15. Resident #3's Quarterly MDS Assessment indicated the resident was on oxygen therapy.</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 09/16/2024, reflected the resident had COPD one of the interventions was give oxygen therapy as ordered.</p> <p>Review of Resident #3's Physician Order, dated 09/20/2024, reflected Titrate O2 2 - 6 L/MIN via NC to keep SPO2 (percentage of oxygen in the blood) equal to or greater than 90%.</p> <p>Review of Resident #3's Physician Order, dated 09/05/2024, reflected Check humidity bottle Q shift. Change & date or add if low every shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</p> <p>Observation and interview on 10/30/2024 at 9:09 AM revealed Resident #3 was in her bed awake. The resident was on oxygen therapy at 3 liters per minute via nasal cannula. The nasal cannula was connected to a humidifier. The humidifier did not have any water in it. She said she was not aware her humidifier did not have any water in it. She said the nurse checked on her earlier but did not check if the humidifier still had water in it.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>2. Review of Resident #4's Face Sheet, dated 10/30/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #4 was diagnosed with chronic obstructive pulmonary disease.</p> <p>Review of Resident #4's Quarterly MDS Assessment, dated 09/22/2024, reflected the resident was unable to complete the interview to determine the BIMS score. Resident #4's Quarterly MDS Assessment indicated the resident was on oxygen therapy.</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 09/06/2024, reflected the resident had COPD and one of the interventions was give aerosol (administration of medication using an inhaler) or bronchodilators (medications that relaxes and open the airways) as ordered.</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 09/06/2024, reflected the resident had oxygen therapy and one of the interventions was administer oxygen as ordered.</p> <p>Review of Resident #4's Physician Order, dated 09/4/2024, reflected Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation) 2 inhalation inhale orally two times a day for SOB.</p> <p>Review of Resident #4's Physician Order, dated 09/20/2024, reflected PRN 2-4 L/NC. May titrate O2 to keep SPO2 equal to or greater than 90%. SPO2check Q shift.</p> <p>Observation and interview on 10/30/2024 at 9:36 AM revealed Resident #4 was sitting in her bed. It was observed that there was a nebulizer machine on her side table and a breathing mask was connected to the nebulizer machine. The breathing mask was sitting on top of the table and was not bagged. She said a nurse would put on the breathing mask every morning and would come back to take it off. Said she did not know where the nurse would put it afterwards.</p> <p>Observation and interview with the DOT on 10/30/2024 at 9:45 AM, the DOT stated the purpose of the humidifier was to moisten the nasal passageway to prevent dryness and skin irritation. She said after administering the breathing treatment, the breathing mask should be cleaned and bagged to prevent cross contamination and respiratory infection. The DOT went inside Resident #3's room and saw the pre-filled humidifier did not have water in it. She said she would get a new pre-filled humidifier and change it. The DOT then went to Resident #4's room and saw the breathing mask was on top of the table and was not bagged. She said she would also get a new breathing mask for Resident #4.</p> <p>Observation and interview with LVN B on 10/30/2024 at 12:30, LVN B stated she did not notice that the pre-filled humidifier was empty or was running low when she did her initial round. She said the humidifier should always have water in it to prevent irritation of the nose and throat. She opened the last drawer of her cart and took a pre-filled humidifier. She said she would check if the humidifier had been changed. She said she would also change Resident #4's breathing mask and make sure it would be bagged every time not in use.</p> <p>Observation and interview with Resident #4 on 10/31/2024 at 6:18 AM revealed the resident was inside her room, awake. It was observed that there was a portable oxygen tank beside the door. A nasal cannula was connected to portable oxygen tank. The nasal cannula was not bagged. She said she used the oxygen tank when she went out of the room. She said she never saw a bag for the nasal cannula.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview with RN E on 10/31/2024 at 7:57 AM, RN E stated she already disconnected the nasal cannula and changed it. She said she made sure the nasal cannula was bagged since the resident was not using it. She said the nasal cannula should be bagged when not in use because it could gather germs and dust that could enter Resident #4's body and it would be detrimental to the health of the resident.</p> <p>3. Review of Resident #5's Face Sheet, dated 10/30/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #5 was diagnosed with chronic obstructive pulmonary disease.</p> <p>Review of Resident #5's Quarterly MDS Assessment, dated 09/22/2024, reflected the resident was cognitively intact with a BIMS score of 14. Resident #5's Quarterly MDS Assessment indicated the resident was on oxygen therapy.</p> <p>Review of Resident #5's Comprehensive Care Plan, dated 09/16/2024, reflected the resident had COPD and one of the interventions was administer oxygen as ordered.</p> <p>Review of Resident #5's Physician Order, dated 09/20/2024, reflected O2 2-4 L/NC. MAY TITRATE O2 TO KEEP SPO2 EQUAL TO OR GREATER THAN 90%. spo2 CHECK Q SHIFT every shift for SOB.</p> <p>Observation and interview with Resident #5 on 10/30/2024 at 1:48 PM revealed Resident #5 was on oxygen therapy at 3 liters per minute via nasal cannula. The nasal cannula was connected to an oxygen concentrator. It was observed that the resident had a portable oxygen tank at the back of her wheelchair. A nasal cannula was connected to the portable oxygen tank, the nasal cannula was coiled on the right wheelchair's handle and was not bagged. She said she been using oxygen since she could remember. She said she would use a portable oxygen tank every time she would go out of the room. She said nobody told her to put the nasal cannula in a plastic bag. She said it was not her responsibility to put the nasal cannula in a bag.</p> <p>Observation and interview with RN A on 10/30/2024 at 1:56 PM, RN A stated Resident #5 would also use oxygen when she went out of her room. She said she would the nasal cannula connected to the portable tank. RN A went inside the room and saw the nasal cannula was coiled on the wheelchair's right handle. RN A disconnected the nasal cannula and told Resident #5 she would change it and put it on plastic bag.</p> <p>In an interview with the Interim DON on 10/31/2024 at 6:42 AM, the Interim DON stated the breathing mask and the nasal cannula should be bagged when not in use. The DON said the proper way of storing the breathing mask and the nasal cannula was putting them inside the plastic bag when the resident was done with the breathing treatment or when the resident was not using the nasal cannula. He said if those breathing apparatus were not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The Interim DON said the staff, including her, were responsible in monitoring that the apparatus used in oxygen therapy were bagged when not in use. He said the expectation was the breathing mask and the nasal cannula would be stored properly. He said another expectation was for the humidifier to have water in it to prevent nasal irritation. The Interim DON said he would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. He said he would do an in-service about making sure there was water in the humidifier and to bag the breathing mask and the nasal cannula when not in use.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview with the Administrator on 10/31/2024 at 7:36 AM, the Administrator stated everything used by the residents should be kept clean. He said the nasal cannula and the breathing mask should be stored properly to prevent respiratory infections. He also said there should always be water in a humidifier to prevent dryness. The Administrator said the expectation was for the staff to do their due diligence in order to provide the highest level of respiratory care. The Administrator said he would coordinate with the clinicians to address the issue.</p> <p>In an interview on 10/31/24 at 1:19 PM, the Interim DON said the provided policy specified only to bag the breathing mask but this policy could also be applied to bagging the nasal cannula as well. The Interim DON said the facility do not have a policy regarding the use of humidifier but if there was a humidifier in the oxygen concentrator, there should be water in it.</p> <p>4. Review of Resident #10's Face Sheet, dated 10/31/2024, reflected that Resident #10 was an [AGE] year-old male admitted on [DATE]. Resident #10 was diagnosed with COPD (a chronic lung disease), dementia (decline in cognitive abilities), chronic kidney disease, and fracture of the right femur (bone in upper leg).</p> <p>Review of Resident #10's Quarterly MDS (Minimum Data Set: tool used to assess health status of resident) Assessment, dated 09/17/2024, reflected that Resident #10 had severe cognitive impairment with a BIMS score of 07. Resident #10 was treated for COPD.</p> <p>Review of Resident #10's Physician Orders, dated 09/16/24, reflected to administer Albuterol Sulfate Nebulization Solution .inhale orally via nebulizer three times a day for Cough related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</p> <p>Review of Resident #10's Comprehensive Care Plan, dated 09/06/2024, reflected that Resident #10 had COPD related to smoking. One intervention was to Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness.</p> <p>An observation on 10/30/24 at 09:13 AM revealed that Resident #10's nebulizer mask was propped on the side of an open drawer on Resident #10's nightstand. The nebulizer mask was not stored in a bag.</p> <p>During an interview on 10/30/24 at 09:15 AM, RN A stated the mask could get dirty or contaminated and should have been covered when the resident was not using it.</p> <p>In an interview on 10/30/24 at 11:10 AM the DON stated that the nebulizer mask should have been kept in a bag when the resident was not using it. He stated that this could become contaminated and cause further respiratory issues for the resident. The DON stated that the staff would receive in-service training.</p> <p>Record review of facility's policy, RESPIRATORY SMALL VOLUME NEBULIZER Policy and Procedure revised 08/2019 revealed PURPOSE: Nebulizer treatment is done . to improve distribution of ventilation . deliver medication . Procedure . 14. Replace nebulizer in identified patient bag, at patient's bedside to keep from contamination of the nebulizer.</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444</p> <p>Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 (Resident #10) of 9 residents reviewed for medications at the bedside.</p> <p>A box containing vials of nebulizer (machine that turns liquid medication into a mist and breathed directly into the lungs) medication was left unattended and unsecured on the nightstand at Resident #10's bedside.</p> <p>This failure could place residents at risk for misappropriation of property and could place residents at risk for accidents, hazards, and not receiving therapeutic effects.</p> <p>The findings included:</p> <p>Review of Resident #10's Face Sheet, dated 10/31/2024, reflected Resident #10 was an [AGE] year-old male admitted on [DATE]. Resident #10 was diagnosed with COPD (a chronic lung disease, dementia (decline in cognitive abilities), chronic kidney disease, and fracture of the right femur (bone in upper leg).</p> <p>Review of Resident #10's Quarterly MDS (Minimum Data Set: tool used to assess health status of resident) Assessment, dated 09/17/2024, reflected Resident #10 had severe cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 07. Resident #10 was treated for COPD.</p> <p>Review of Resident #10's Physician Orders, dated 09/16/24, reflected to administer Albuterol Sulfate Nebulization Solution .inhale orally via nebulizer three times a day for Cough related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</p> <p>Review of Resident #10's Comprehensive Care Plan, dated 09/06/2024, reflected Resident #10 had COPD related to smoking. One intervention was to Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness.</p> <p>An observation and interview on 10/30/24 at 09:13 AM revealed a box containing vials of medication was left unattended and unsecured on the nightstand at Resident #10's bedside. The vials contained liquid medication used in a nebulizer to administer breathing treatments. The resident was lying in his bed. Resident #10 stated a family member brought the medication, but he was not sure when. The box of medication had a Walgreen label with Resident #10's name on it.</p> <p>During an interview on 10/30/24 at 09:15 AM, RN A stated the medication should not have been in the resident's room unattended. RN A stated she did not know when the medication was brought to the resident. RN A stated the medication in the resident's room was not the current prescription ordered by the doctor. RN A stated Resident #10 might try to take medication when it's not the right time. RN A removed the box of medication from Resident #10's room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/30/24 at 10:30 AM, the DON stated the medication should not have been left unsecured in Resident #10's room. He stated the resident did not self-administer medication and an assessment was required to determine if a resident could safely administer their own medication.</p> <p>In an interview on 10/30/24 at 02:30 PM, RN B stated the medication should not have been in Resident #10's room. She stated the family member was notified and asked to give any medication to a nurse and not leave it in the resident's room. She stated in-service training would be provided to staff.</p> <p>Review of the facility's policy, titled Storage of Medications, reflected Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. Undated.</p> | | |

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| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure the ice machine and the ice scoop, located in the kitchen area, was cleaned. 2. The facility failed to ensure the food stored in the refrigerator and freezer were labeled with the stored date. <p>These failures could place residents at risk for cross contamination and other air-borne illnesses.</p> <p>Findings included:</p> <p>Observations of the only kitchen with Dietary Manager A on [DATE] from 2:09 PM to 2:15 PM AM reflected the following:</p> <ul style="list-style-type: none"> *The ice machine, located in the kitchen area, had black stains near the inside door hinges. The inside opening of the ice machine had lights stains. *The ice scoop, hanging in a clear plastic holder, had dirt debris along the bottom of the holder. *One large stainless-steel container of reddish sauce, located in the refrigerator, did not have a stored date. *One zip locked bag of bread sticks, located in the freezer, did not have a stored date. *One zip locked bag of tater tots, located in the freezer, did not have a stored date. *One zip locked bag of frozen fish fillets, located in the freezer, did not have a stored date. *One zip locked bag of red potatoes, located in the freezer, did not have a stored date. *Two large bags of breaded chicken tender, located in the freezer, did not have a stored date. <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In an interview and observation on [DATE] at 2:15 PM, Dietary Manager A stated she had been the dietary manager of the facility for a month. She stated food should be labeled and dated to prevent expiration, and to know when they should be eaten or thrown away. She stated the risk for the residents could be eating contaminated food, it could cause food poisoning, vomiting, and diarrhea. DM A stated they cleaned the ice machine every day. DM A observed the blacks spot on the inside of the ice machine, and she stated it should not be there. She stated the ice machine should be clean because it was where they get the ice for the residents. She said everything served for the resident should be cleaned and expected staff to date and label all the items/food/drinks delivered.</p> <p>In an interview and observation on [DATE] at 2:15 PM, Dietary Manager C stated he was a dietary manager at a sister site, and had come to the facility to assist in training Dietary Manager A. He stated the food should be dated and labeled to ensure no expired food were served. He stated the ice machine should have been cleaned to ensure the ice/water given to the residents were safe to drink. He stated the ice scoop holder should have had holes on the bottom to drain the water from the scooper, to prevent mold formation.</p> <p>In an interview on [DATE] at 9:10 AM, Dietary Aide N stated she occasionally labeled and dated the food delivered to the facility. She stated she did not notice some of the foods were not dated and labeled. She stated the risk of not dating food when stored, could result in cooking and serving expired foods to residents. She stated residents might get sick if they eat expired food. She stated they clean the ice machine inside and outside at least once a month.</p> <p>In an interview on [DATE] at 9:17 AM, the Administrator stated items for kitchen delivered should be dated to know when it was delivered and when the food should be disposed. He stated the risk would be the resident, who were already vulnerable, could eat/drink something expired. He stated the expectation was for foods delivered to be labeled and dated. He stated the ice machine should be always cleaned because it could cause infections. He stated he would coordinate with the Dietary Manager to ensure the food delivered were dated, and the ice machine and ice scooper were kept clean.</p> <p>Record review of the facility's policy Infection Control Policy Food Service/Procedure ([DATE]) revealed It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness.</p> <p>PROCEDURES:</p> <p>1. DIRECTOR OF FOOD SERVICE RESPONSIBILITIES</p> <p>A. Provide safe food services for residents and employees</p> <p>Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].</p> <p>Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES</p> <p>(continued on next page)</p> | | |

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| F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | SUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #3) of eight residents observed for Infection Control.</p> <p>The facility failed to ensure that CNA C changed her gloves and performed hand hygiene while providing incontinent care to Resident #3.</p> <p>This failure could place the residents at risk of cross-contamination and development of infections.</p> <p>Findings included:</p> <p>Review of Resident #3's Face Sheet, dated 10/30/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #3 was diagnosed with gastroenteritis (gastrointestinal infection) and colitis (inflammation of the large intestine).</p> <p>Review of Resident #3's Quarterly MDS Assessment, dated 09/22/2024, reflected the resident was cognitively intact with a BIMS score of 15. Resident #3's Quarterly MDS Assessment indicated the resident was always incontinent for bladder and bowel.</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 09/16/2024, reflected the resident had bowel/bladder incontinence related to impaired mobility and one of the interventions was check as required for incontinence.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation and interview with CNA D on 10/30/2024 at 9:52 AM revealed CNA D was about to provide incontinent care to Resident #3. CNA D washed her hands and put on a pair of gloves. CNA D opened a plastic bag, put it on top of a trash can, and then pulled the trash can near her. She did not change her gloves and sanitized her hands after touching the trash can. She prepared the wipes on the overbed table, took a brief, opened it, and put it beside the head of the resident. She raised the bed and lowered the head of the bed. CNA D unfastened the brief on both sides and pushed the front part of the brief between the legs of the resident. CNA D pulled some wipes and started to clean the front part of the resident. She did it five times. After cleaning the front part of the resident, CNA D assisted the resident to roll towards the wall and started cleaning the bottom of the resident. During the process of cleaning, the resident had a bowel movement. When the resident was done, CNA D started to clean the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief and throw it in the trash can. She then took the brief placed beside the resident's head and put it on the resident's bottom and fixed it. CNA D took off her gloves and put on a pair of gloves. She did not sanitize her hands before putting on the new pair of gloves. She took a packet of ointment from the resident's drawer and put it on the resident's bottom. CNA D took off her gloves and put on a new pair of gloves. She did not sanitize in between changing of gloves. CNA D rolled back the resident, fixed the new brief, and taped the brief on both sides. CNA D went to the bathroom and washed her hands. CNA D stated she washed her hands before and after doing incontinent care. She said she did pull the trash can towards her but was not able to change her gloves after touching the trash can. She said she also should have changed her gloves after touching the trash can because gloves were considered already dirty. She said she also should have changed her gloves after cleaning the resident's bottom and before touching the new brief because her gloves were considered soiled after they came in contact with the soiled brief. She said the hands should be washed or sanitized before putting on a new pair of gloves. She said the purpose of changing of gloves and doing hand hygiene was to prevent infection. She said she had a training for hand hygiene and incontinent care but still forgot to do the right procedure.</p> <p>In an interview with the Interim DON on 10/31/2024 at 6:42 AM, the Interim DON stated hands should be washed before and after incontinent care, or any care for that matter. He said gloves should be changed after touching any soiled items, like the trash can and the soiled brief. He said gloves should be changed after cleaning the resident's bottom. He said hands should be sanitized in between changing of gloves. He said not changing the gloves after touching soiled items and not sanitizing the hands in between changing of gloves could result to cross contamination and infection. He said the expectation was for the staff to be mindful in following the procedures pertaining to infection control. The Interim DON said he would do a one-on-one in-service with the concerned staff and then would do an in-service about infection control for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that she would personally monitor infection control.</p> <p>In an interview with the Administrator on 10/31/2024 at 7:36 AM, the Administrator stated not washing the hands nor sanitizing them could contribute to cross contamination. He said not changing the gloves after touching soiled items could contribute to the development of infection as well. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he would collaborate with the Interim DON to in-service the staff about infection control.</p> <p>Review of facility policy, Perineal Care Policy/Procedure - Nursing Clinical revised 07/2013 revealed Policy . 3. Prevent irritation or infection.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of facility policy Hand Washing Policy/Procedure - Nursing Services revised 04/2012 revealed POLICY: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff.</p> | | |